Section 1: Personal Information

lame lc			Identificatio	entification Number		
Last Name	First Name	M.I.			Assigned ID or Social Security Number	
Date of Birth	onth Day	Year	Gender:	Male	Female	
Important! Be sure to verify the correct format of your address at <u>http://zip4.usps.com/zip4/welcome.jsp.</u>						
Street Address				F	P.O. Box	
City			State	Z	Zip + 4	
State E-mail:	Personal E-mail:					
State Phone: (_) P	Personal Phone: () _		<u>M</u> o	bile	
Section 2 : Reason For This Enrollment or Election Change Request						
Check the box that applies. The numbers in parentheses are for agency use.						
Open Enrollment (5 Initial Enrollment for N			(01)			
, 0	Event/Documentation to Second	upport the Event	ntation as inc	licated. D	ate of Event:	

MONTH/DAY/YEAR

ible dependents. up to \$2,750.)

Amount per regular paycheck

I do not wish to participate in health care coverage (W) No change to my current health plan selection and family members/membership level (If you check either box above proceed to Section 5.)

A. Health Plan Selection - Check the box that applies

No change to my current health care plan

STATEWIDE HEALTH PLANS

Administered by Anthem Blue Cross Blue Shield* COVA Care (with preventive dental) (ACCO) COVA Care + Out of Network (ACC1) Administered by Aetna* COVA HealthAware (with preventive dental) (CHA) COVA HealthAware + Expandel.3 (ar2 (a)-19.2 (n)-14.2 (d)-20.9 (e)-2